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Supreme Court, U.S.
FILED
FEB 9 2001
OFFICE OF THE CLERK

No. 00-848

IN THE

Supreme Court of the United States

JIMMY WALLACE MCNEIL,
as Independent Executor and Representative of the Estate of Michael Jay McNeil,

Petitioner,

v.

FORTIS INSURANCE COMPANY
(f/k/a TIME INSURANCE COMPANY),

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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REASONS FOR GRANTING THE WRIT

I. THE FIFTH CIRCUIT'S RESTRICTIVE INTERPRETATION OF THE ADA CONFLICTS WITH THE DECISIONS OF OTHER COURTS AND IS WRONG.

A. There Is a Circuit Split Regarding Title III's Application to Insurance.

Though erring on the merits, the Fifth Circuit correctly recognized that its views were fundamentally incompatible with the views of the Second Circuit in *Pallozzi* v. *Allstate Life Ins. Co.*, 198 F.3d 28, 32 (CA2 2000) (as amended). App. A14-15. Respondent nonetheless argues that there is no conflict between the Fifth and Second Circuits because *Pallozzi* addressed only access to insurance, whereas the decision

below deals with discriminatory terms of an insurance policy. BIO 11. Not only does that argument ignore the language and reasoning of the *Pallozzi* decision, it also posits a false dichotomy between equal access by the disabled to a policy itself and equal coverage of the disabled for identical treatments under such a policy.

Pallozzi held that the ADA's § 501(c) safe-harbor provision, 42 U.S.C. § 12201(c) – applicable to "underwriting risks, classifying risks, or administering risks" consistent with state law – necessarily implied ADA coverage of "insurance underwriting practices" that fell outside the bounds of that safe harbor. 198 F.3d at 32. While the facts of *Pallozzi* itself dealt with one aspect of underwriting, classifying, and administering risks – the refusal to sell a policy at all to certain groups – the Fifth Circuit correctly recognized that underwriting, classifying, and administering risks are also necessarily reflected in the *substance* of a policy. App. A12 n.10. The Fifth Circuit's refusal to apply the ADA to underwriting decisions reflected in disability-based coverage limitations thus necessarily contradicts the Second Circuit's holding that the ADA does apply to underwriting decisions. That such underwriting decisions in *Pallozzi* were implemented at the point of sale rather than incorporated into the limitations of the policy itself is immaterial to the legal analysis based on the safe-harbor of § 501(c). Indeed, recognizing that § 501(c) provided only limited protection for "the content" of insurance policies, the Fifth Circuit could reach its result only by holding, contrary to the Second Circuit, that the safe-harbor provision was essentially meaningless surplus providing an oddly "partial[]" exemption from a supposedly incorrect interpretation of Title III. App. A12 n.10.

These divergent views of the import of the safe-harbor provision are the core of the split between the Fifth and Second Circuits. Either discriminatory underwriting decisions outside the safe harbor are covered by Title III or they are not. Whether such discriminatory decisions are reflected in limi-

tations on sales or in limitations on coverage is immaterial to the legal question dividing the circuits.

Respondent's emphasis that several other circuits have reached the same result as the Fifth Circuit at most suggests an imbalance in the breakdown of the split, not the absence of a split.[1] That the Fifth Circuit has a certain amount of company in its error only demonstrates the importance of the issue and the greater need for correction by this Court. Furthermore, the disagreement and confusion among federal judges is deeper than is reflected by the circuit count alone. For example, the Sixth Circuit's *en banc* decision in *Parker* v. *Metropolitan Life Ins. Co.*, 121 F.3d 1006 (CA6 1997), *cert. denied*, 522 U.S. 1084 (1998), was bitterly divided, with the Chief Judge and four others dissenting based on their correct view of the § 501(c) safe harbor. *Id.* at 1008, 1019-21. And a plethora of district court judges have not only agreed with petitioner's position, but found that result to be plain from the language of the statute. See Pet. 10-11 (citing cases). These additional conflicting views highlight both the frequency and importance of this issue and the depth of confusion regarding two incompatible, yet simultaneously "plain," readings of the ADA's language. Such a divergence of views among federal judges at both the circuit and district levels calls for this Court's intervention. See STERN, GRESSMAN, SHAPIRO & GELLER, SUPREME COURT PRACTICE § 4.6, at 177 (7th ed.1993) (discussing significance to certiorari decision of closely divided *en banc* decisions and citing cases); *id.* § 4.8, at 179 (discussing significance of district court decisions as part of a broader conflict and citing cases).

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[1] And while the Seventh Circuit's opinion in *Doe* v. *Mutual of Omaha Ins. Co.*, 179 F.3d 557 (CA7 1999), *cert. denied*, 120 S. Ct. 845 (2000), was cited by the Second Circuit in *Pallozzi*, 198 F.3d at 31-32, it was cited for the proposition that the ADA *did* extend to the refusal to sell insurance, not for the Seventh Circuit's contradictory further proposition that the ADA did not extend to the content of insurance policies.

B. The Exclusion of Discriminatory Insurance Terms from Coverage under Title III Is Erroneous.

Ignoring the flaw in defining a good or service in terms of the forbidden discrimination itself, Pet. 11-13, respondent continues the conceptual error of the Fifth Circuit by misstating the question presented as whether Title III governs the content of insurance "when the same coverage is offered to all persons that apply." BIO i. The problem, of course is that the "same coverage" is not offered to "all persons" where the policy itself incorporates an exclusion expressly targeted to only some persons with a particular disability. As this Court held in *Alexander* v. *Choate*, 469 U.S. 287, 301 n.21 (1985), "[t]he benefit itself, of course, cannot be defined in a way that effectively denies otherwise qualified handicapped individuals the meaningful access to which they are entitled * * *." (Citation omitted).

This basic conceptual issue was raised during the January oral argument in *PGA Tour* v. *Martin*, No. 00-24. There, the questioning turned to whether any given "rule" was essential to the game of golf, and hence was an intrinsic part of the privilege or advantage being offered by a public accommodation. But there, the rules were facially neutral requirements having a disparate impact on persons with certain types of disabilities, *not* express exclusions or limitations based on a disability itself. Thus, while walking may be harder (or even impossible) for the disabled, that may well be part of the game of golf as defined by the promoter of the game. But there seems little doubt that a rule keyed directly to a disability – hypothetical Rule 22: A golfer must not have a physical handicap – would not be permissible. The essential distinction when it comes to intangible goods or services that are otherwise defined by the provider is that the protected trait – disability, race, etc. – cannot be the *trigger* for the rule,

whereas facially neutral rules may be allowed to have disparate impacts in many cases.[2]

Respondent's concern over petitioner's supposed effort to require insurers to offer *different* goods or services that would better suit the disabled thus misses the point. Petitioner merely sought access to the exact same coverage for the exact same treatments available to non-disabled persons. Time's policy already covered treatment for pneumonia and cancer up to a million dollars, but then denied that very coverage for *identical treatment* to persons also disabled with AIDS. This case is not about whether an insurance policy is required to cover a particular drug or a particular treatment for AIDS itself. Rather, this case is about whether Time, whose policies indisputably cover treatment of pneumonia and cancer, may nonetheless limit coverage for such otherwise available treatment for the sole reason that the insured also is disabled with AIDS. There is no attempt to obtain coverage different that that provided the non-disabled, but rather to have the *same* treatments for pneumonia and cancer covered *regardless* of whether the insured is disabled.

The distinction between defining a product to contain limited substantive coverage and discriminating based on disability by selectively limiting *who* may access otherwise available coverage was expressly addressed in the legislative history regarding Title I of the ADA. Any limitations or exclusions in coverage provided through employment must ap-

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[2] Insofar as the *PGA* case is likely to discuss how one defines the baseline product or service, whether a particular criteria is fundamental to that product or service, and thus whether its removal would constitute a "different" product, it might be appropriate to hold this petition for that *PGA* decision. On the other hand, this petition provides an excellent vehicle and a useful concrete example for discussing what is fundamental in a product given that sound actuarial principles and state law are the dispositive determiners of what is fundamental to an insurance product. It is undisputed that respondent's limitation on coverage for persons with AIDS was *not* based on sound actuarial principles.

ply equally to all employees, not simply to those employees with a particular disability or illness:

> A limitation may be placed on the types of drugs or procedures covered[,] *e.g.*, a limit on the number of x-rays or non-coverage of experimental drugs or procedures; but, that limitation must apply to persons with or without disabilities. All persons with disabilities must have equal access to the health insurance coverage that is provided by the employer to all employees.

S. REP. No. 101- 116, at 29 (1989). In this case, respondent did not limit coverage for a particular treatment or procedure but rather imposed a disability-based limitation that provided different persons with different coverage for the same treatment or procedure. That is forbidden discrimination.

II. THE DECISION BELOW CONFLICTS WITH DECISIONS FROM THIS COURT AND NUMEROUS OTHER COURTS RECOGNIZING THE MUCH-NARROWED SCOPE OF ERISA PREEMPTION.

It is undisputed that the Fifth Circuit's dismissal of *Travelers* and its progeny conflicts with the sweeping effect given those cases by numerous other courts. Pet 16-17. Unable to defend the Fifth Circuit's cavalier disregard for *Travelers*, respondent instead claims that it does not matter because most of the state-law claims would have been preempted anyway and two others were rejected on the merits. BIO 12-13.

First, given that the Fifth Circuit never bothered to engage in the required analysis, respondent's claim of harmlessness is pure speculation. Furthermore, as explained in the petition, state-law regulation of a product in the market – here a health care insurance product – applicable regardless of whether that product is purchased by an ERISA plan or by an individual, is precisely the type of neutral regulation that *Travelers* held was not preempted under a proper "connection" analysis. Pet.

17-18. [3] The cases respondent cites to suggest that the result would be the same are, on the whole, inapposite, with most not even citing *Travelers* or its progeny. Respondent's only case citing *Travelers*, *Bast* v. *Prudential Ins. Co.*, 150 F.3d 1003, 1007-08 (CA9 1998), *cert. denied*, 528 U.S. 870 (1999), merely recites the *Travelers* test and then proceeds to ignore it and rely on questionable applications of pre-*Travelers* case-law. And *Bast*'s analysis of the insurance savings clause fairly well flies in the face of *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 742-43 (1985). Suffice it to say that such questionable analysis from the Ninth Circuit falls far short of demonstrating that the Fifth Circuit's erroneous methodology was harmless.

Second, although petitioner sought remedies under a variety of legal theories, each claim at issue here was based upon a duty imposed by state insurance law, and hence each is preserved by the insurance savings clause. Pet. 18-19. In most instances, that duty was respondent's insurance-specific obligation to base the terms and limitations of its insurance policies on sound actuarial principles. Regardless of whether the breach of that duty is conceptualized as a tort, as a contract action incorporating the state-law insurance duty, or as a statutory cause of action under specific remedial provisions of the insurance code, the result is the same: the underlying duty is a specific regulation of insurance and thus is not preempted by ERISA. The foundation of these claims in not, as respondent would have it, a right to receive ERISA benefits, but rather a prior right to be free from unlawful insurance prac-

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[3] The relevance of this Court's upcoming decision in *Egelhoff* v. *Egelhoff*, No. 99-1529, is that the opinion will likely discuss the proper application of the *Travelers* test, and in particular the "connection" aspect of that test. While the factual scenarios differ, the clarification of the relevant legal principles in *Egelhoff* could easily have a bearing on the approach used in this case. A hold for *Egelhoff* thus might be appropriate.

tices *regardless* of whether the insurance is purchased by an ERISA plan or otherwise.[4]

As in *Unum Life Insurance Co. of America* v. *Ward,* 526 U.S. 358 (1999), even direct contract actions are saved from preemption where the contractual duty or defense alleged is one that is unique to insurance. In *Unum* it was a notice-prejudice rule entitling the claimant to recover benefits despite the lack of notice. 526 U.S. at 371 ("notice- prejudice rule is distinctive most notably because it is a rule firmly applied to insurance contracts, not a general principle guiding a court's discretion in a range of matters"). Here, it is an incorporated obligation that policy limits be based on sound actuarial principles, barring the insurer from applying a policy limit not so based.[5]

Finally, as noted in the petition, Pet. 7 n.3, and never disputed by respondent, the Fifth Circuit's rejection on the merits of two state-law discrimination claims was inextricably bound up with the court's error regarding discrimination under the ADA, and hence those determinations are neither adequate nor independent grounds if this Court finds for petitioner on the issue of discrimination under the ADA. The proper methodology for and scope of ERISA preemption thus would be important for those two claims as well on remand.

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[4] In this sense the basic right to a lawfully configured insurance product is no different than the right to have medical care or child care comply with uniform state laws, regardless of whether an ERISA plan or somebody else is paying for such care.

[5] As it appears that this Court is considering revisiting the application of ERISA's insurance savings clause, *see Montemayor* v. *Corporate Health Ins., Inc.*, No. 00-665 (*cert.* filed Oct. 24, 2000) (views of the United States invited, Jan. 8, 2001), the application of that clause in this case may provide an useful vehicle to that end, or may be affected by the *Montemayor* case should the Court decide to grant that petition.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted. Alternatively, this petition should be held for any or all of *Egelhoff* v. *Egelhoff*, No. 99-1529, *PGA Tour* v. *Martin*, No. 00-24, and *Montemayor* v. *Corporate Health Ins., Inc.*, No. 00-665.

Respectfully submitted,

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Dated: February 9, 2001.